I plan on voting for cloture because I want to see the conference report on Medicare voted on the floor of the Senate. I have stated that I am undecided on final passage. That is because, as a general rule, in the process of negotiations, legislation doesn't get less expensive, it gets more expensive through spending to attract more support and votes. I hope to act as a counterbalance with the clear message that, if spending gets out of hand, I will not vote for the bill.

I am not happy with creating a new program that could lead to a monstrous program in the future. That is why I opposed the bill as it left the Senate, because it was not limited to just the most needy and I felt it broke the budget. It was later proved that I was right in the assessment that it would break the budget, and with more accurate budget figures the conference committee set to work to reduce the scope of the program to keep it below $400 billion for 10 years and within the parameters of the budget. This, in effect, forced the conference committee to means test the program and keep certain provisions that would hold the user accountable by forcing that patient to participate with a deductible and the so called ''donut hole.''

In my view, it is very difficult to have a third party pay system and yet maintain accountability. Users feel that they have already paid for the system and are going to utilize it to its maximum to get their just return, and providers feel that it has already been paid for and creates no particular hardship on the individual so they charge with little restraint the third party. So utilization is regulated. And we end up with regulations like we have now in the current Medicare system, which prevents a patient from paying for their own medical care if they want, and it prevents the physician from receiving cash outside the system that could reduce the burden on taxpayers. It ends up creating a system where the close patient-doctor relationship is disrupted to where the patient can't use whomever they desire to care for their medical needs. So what we have today is a Medicare system that is not actuarially sound and, if not reformed, will lead to much higher payroll taxes and huge demands on the general budget. That is why I was pleased to see some reform proposals on medicare emerge from the conference committee, such as health saving accounts.

When I served in the Colorado State Senate, I sponsored, with State Representative Phil Pankey, a bill to put in place an individual medical saving account; and Colorado became the first State to have such a program.

Unfortunately, in an effort to pass the bill, we allowed the program to become so limited that the risk pool became too small to function as insurance against future liabilities. Consequently, when Colorado moved to a modified flat tax, this program became a victim of tax reform.

This Congress puts forth a health savings account that will work. Individuals can put in $5,000 a year or a family can put up to $10,000 per year and save on their taxes. The income builds up within the health savings fund without tax liability and, finally, can be pulled out to pay for the family medical needs without paying additional taxes.

This is wonderful reform because it reestablishes the doctor-patient relationship and makes individuals responsible for their own health care with much fewer regulations, and it brings common sense to the decisionmaking process. It builds upon previously enacted medical savings accounts that have been limited to small business and the self-employed by Congress.

One other attractive feature in this bill is that the elderly are not forced to participate. It is voluntary. It also tries to prevent large businesses and local governments from dumping their current prescription programs into the Federal system to save themselves future liabilities and further burden the Federal prescription drug program.

The other side has repeatedly made the claim that this bill is full of giveaways to Republican contributors. This is simply not true. That is simply more absurd ''medi-scare'' tactics by the opponents of a bipartisan drug benefit for our Nation's seniors and the disabled.

The argument I find most amusing is the claim that this bill will lead to increased drug company profits. The reason this bill is so desperately needed is because our Nation's seniors and the disabled, particularly those with low incomes, are unable to afford their prescriptions today. Let me stress that again. The reason this bill is so desperately needed is that our Nation's seniors and the disabled, particularly those with lower income, are unable—unable—to afford their prescriptions today. Today they are forced to choose between food and rent and taking their medicine. We have all heard the stories of seniors cutting their pills in half to get by and in so doing taking a lower dose than their doctor prescribed.

When this Medicare prescription drug benefit goes into effect, they will be able to get their prescriptions filled. Of course, this is going to lead to increased drug sales. Surely, this is no surprise to anyone. With new technologies and new medications, invasive procedures become less likely. Any prescription drug bill that works is going to lead to increased drug sales. That is just common sense.

Where are the medicines supposed to come from except the manufacturers of those medicines? Every single medical prescription drug bill introduced by these naysayers would also increase drug sales and the bipartisan conference report has the same basic drug benefit structure that passed the Senate by a vote of 76 to 21.

The Congressional Budget Office has concluded that the competitive approach in this bipartisan drug benefit will do better at controlling drug costs than other proposals. To suggest that no one should support a Medicare drug benefit because it will lead to increased drug sales turns logic on its head. If this were our basic principle, then we should not have food stamps because this will lead to increased profits by grocery stores and farmers. How about housing subsidies? This might lead to profits by construction companies and utility companies and increased sales of lumber, bricks, and nails. This is just an absurd issue, and it is easy to see why.

I am here to tell you that this bill will strengthen and improve the Medicare Program. The spending on this bipartisan prescription drug bill goes to better benefits for America's seniors and the disabled.

As I draw to a conclusion, unfortunately, those who want universal health care and the big Government solution to drugs, making people more vulnerable to Government control, are vehemently opposed to this conference report.

The conference report lays out a plan for Medicare reform and a way to help the most needy. It is a balance that does not come easily and not without a lot of discussion on both sides of the aisle. We should at least have a vote on the bill. It is time to put partisan obstruction aside and think about what is good for America.

I ask my colleagues to join me in voting yes on cloture to stop the filibuster and to help hold down costs to within the budget limits.

Mr. President, I yield the floor.

The PRESIDING OFFICER (Mr. TALENT). The Senator from Oregon.

Mr. WYDEN. Mr. President, as Congress considers Medicare and prescription drugs, I keep remembering the older people whose stories spurred me to choose a career in public service. For 7 years, before I came to the Congress, I worked with seniors and spent many hours visiting with them in their homes. During those visits, seniors would often bring out shoeboxes full of health insurance policies that were supposed to fill the gaps in their Medicare. It was common for a senior then to have seven or eight of these policies, and many of them were not worth the paper they were written on. Slick, fast-talking insurance hucksters kept coming around and scaring the older folks, and it was heartbreaking to see seniors ripped off this way.

After working all their lives, seniors would go without each month because they were paying for junk health insurance policies with the precious funds they needed to pay the heating bill or buy some groceries.

When I got elected to the Congress, I vowed to stop this fleecing of America's seniors. I helped to write the first and only tough law to stop the ripoffs of private health insurance sold to the elderly. This statute has worked to drain the swamp of fly-by-night Medigap policies that used to rob seniors blind.

The days of the shoebox full of health insurance policies are gone, but the skyrocketing drug costs and lack of access to medicine—two of the problems that plagued seniors even back then—are more of a problem today.

During those home visits I made with seniors, I saw firsthand the pain they felt when they couldn't afford life-saving medicine. Their anguish was physical, and it was emotional. They feared for their futures. They worried that the choices that financial constraints forced on them would not be the right ones.

We are very familiar with those stories today. Caseworkers in every office in the Senate hear them constantly. A senior is supposed to take four pills, but because they can't make ends meet, they take three or two. Eventually, that senior ends up in the hospital where the hospital portion of Medicare, known as Part A, covers drug treatment, but often it is too late.

I have tried to rewrite stories such as that since I came to the Congress. That is why I worked with Senator PRYOR's father so that States could bargain aggressively and get more for their Medicaid dollar when buying prescription drugs that would help the low-income elderly. I have tried to expand coverage for generic drugs. I have worked to supplement those efforts by creating new health care options for seniors, including in-home care and increased payments for providers in low-cost areas, funds that can be used to offer prescription drug benefits to some of the elderly. Because of my history, I am acutely aware that there is so much more to do. The reason the debate on this bill is so important is that Government has the obligation to do right by a generation that deserves our respect and care and not give those seniors the runaround.

My years working with the older people have governed the decision I have made on this bill. I have tried to keep the focus on determining whether this prescription drug benefit legislation would make a genuine positive difference for a significant number of older people or whether it falls short of that objective.

As part of the process, I have developed a set of criteria to evaluate this legislation. I would like to describe the questions I believed were key and the answers I have found.

The first question I asked was: Does this bill help a significant number of older people with low incomes or big prescription drug bills? In their editorial endorsing this legislation, the New York Times stated:

> The bill is strongest when it comes to the most important target groups: Elderly people with low incomes or very high drug bills.

It is not my job to take the word of editorial writers simply because they are just one voice in a chorus that comes from both sides. So I have gone to some length to examine the figures and data from all perspectives. I looked at the data that has been available from those strongly in favor of the legislation, such as the Federal Center for Medicare and Medicaid Services. I looked at the information from those strongly opposed to the bill, such as the nonprofit Center on Budget and Policy Priorities.

The critics say the legislation has significant gaps in coverage for seniors, especially those of modest income. Proponents of the bill claim that millions of seniors will have coverage they did not have before. There does seem to be truth on both counts. So I have tried to keep the focus on figures that were beyond any doubt. Using data from the 2000 Oregon census, my staff and I have determined that 78,829 older people in Oregon had prescription costs that exceeded $5,000, and under this bill these seniors would have their prescription drug costs reduced by one-half.

Using 2001 data from the nonprofit Kaiser Family Foundation, my staff determined that Oregon has 106,765 seniors on Medicare with incomes at or below $12,123 for an individual or $16,362 for a couple.

Under this legislation, this low-income group would pay no premium for their drug coverage and would be responsible for a copay of no more than $2 for generic drugs and no more than $5 for brand name drugs. The least fortunate would pay only $1 for generics and $3 for brand name drugs.

Most seniors with low incomes and high drug costs are likely to be eligible for both Medicaid and Medicare. These older people are known as dual eligibles. This legislation assures that they receive at least some measure of prescription drug coverage through Medicare so they are not left at the mercy of perennial State budget crises and so they will not have to compete against other vulnerable groups in State budget battles.

Another factor I considered was the expectations for this legislation. What I hear from seniors at senior centers and at meal sites is that expectations are very high. I know some seniors will find that this bill does not offer benefits that match their expectations. Some seniors fear this bill is going to fence them in and require that they participate in a program they do not support. So at the very least, because this program is voluntary, it strikes me as a plus that no senior will be forced to accept the terms of this legislation.

So on this particular issue, with respect to who benefits, what we found that seniors in my State with very high drug bills would have their costs reduced by half. We found a great many low-income people who would receive very significant benefits with no premium and a very modest copay for their drugs.

The second question we asked was: How does this bill affect seniors who currently get their prescription drug coverage through corporate retiree benefit packages? Almost every day now we pick up a newspaper and read about another employer dropping their retiree benefits or cutting them back significantly. There has been a dramatic reduction in corporate retiree health benefits, and it is taking place right now before the enactment or rejection of any legislation.

The percentage of large employers offering retiree health benefits over a relatively short period of time has dropped from 66 percent to 34 percent. Consistently, the employers who keep coverage have required the retirees to shell out for higher copayments and premiums. Employers say they have to make these cuts because of the rising costs of health care and the effects of a lousy economy. Now along comes the Congress with a bill that many believe will dramatically affect retiree plans in the future.

It seems to me that with legislation offering $71 billion to employers to keep their coverage, these funds can only be a plus in developing a strategy for getting more employers to retain existing coverage. This is a subsidy the companies are not going to see absent this legislation.

So I ask the Senate: Will companies not be less likely, not more likely, to drop coverage if they get the funds offered tax free under this legislation?

I would also note that corporate retiree provisions in the conference report are better than the provisions in the original Senate bill which was approved by more than 75 members of this body.

Bernstein Research says employers spend about $1,900 per year per senior on retiree drug benefits. Based on my calculations, this bill gives corporations a significant tax-free incentive to cover not only retiree drug benefits but other senior health care costs as well.

The next question I asked was: Does this bill significantly undermine traditional Medicare? Critics of the bill have focused on this issue, and I share their view that seniors believe in Medicare, want to modernize it, and do not want it undermined.

The critics seem to believe that any effort, however, to create more choices outside the basic Medicare fee-for-service program is a mistake. I disagree. I believe seniors need good quality choices beyond fee for service. I simply believe those choices must be accompanied by strong consumer protections and that it is essential to strike a balance, making sure that the new choices never, ever cut off access to traditional Medicare that seniors know so well and a program with which they feel so comfortable.

I have never been opposed to private sector involvement with Medicare. In many Oregon communities, upwards of 40 percent of the elderly get their Medicare through private plans. The law I wrote stopped the rip-offs of private health supplements to Medicare, standardized 10 private sector policies to help seniors fill the holes in Medicare, and consumer advocates across the country believe that law is working.

The key to making the private sector choices work is a combination of strong consumer protections and a level playing field between the private sector choices and health services offered by the Government. I have considerable ambivalence about how this legislation will affect that balance.

In the bipartisan prescription drug legislation I drafted with Senator SNOWE, we offered private sector options for seniors that contain strong consumer safeguards. Our bill was known as SPICE, the Senior Prescription Insurance Coverage Equity Act. It did not tilt the playing field toward the private sector the way the legislation before Congress does today with its health savings accounts and premium support. Unfortunately, the health savings accounts in this bill, which are tax breaks for purchasing health care, are structured to disproportionately benefit the healthy and the wealthy. Seven billion dollars of tax subsidies are directed to these accounts. This has gone from a demonstration project to a major expense, one that siphons away funds that could go to beef up the drug benefits.

Another drawback of the legislation is the premium support provisions, which are designed to test competition between traditional Medicare and private plans. These could drive seniors out of the fee-for-service programs they want. Premium support demonstrations could allow insurance companies to cherry-pick the healthy seniors, leaving the truly ill to go to poorly funded Government programs that are sicker than they are. Even though premium support doesn't start until 2010, I don't believe it has a responsible role to play in this legislation.

I don't believe this legislation is going to wipe out traditional Medicare. I do believe that Congress is going to have to be extraordinarily vigilant with respect to ensuring that traditional Medicare can coexist and prosper along with the new choices. Without careful management, it is certainly possible that health savings accounts and premium support could tilt the Medicare Program away from providing traditional fee for service for all the seniors who want it. If this legislation passes, it will be the job of the Congress to make sure that does not happen.

The next question I asked is especially important. Virtually every senior in America wants to know: What will this legislation do to keep their prescription drug bills down? In my mind, the key to effective containing of prescription costs is to make sure older people have bargaining power in the health care marketplace. Today, when a senior gets his or her prescriptions through a health plan with many members, that plan has significantly more bargaining power than that same senior would have by walking into a Walgreen's, a Safeway, or a Fred Meyer to buy medicine. Getting seniors more purchasing power by getting them into large buying groups is an absolute prerequisite for a long-term strategy for keeping prescription costs down for older people.

That was the principle behind the Medicaid drug rebate law that I helped author with the first Senator Pryor. That is the principle that Senator SNOWE and I have proposed in our bipartisan legislation. We looked to a market-based proposal that was built around the Federal Employees Health Benefits Plan, a program that has been proven to contain costs because of the sheer size of the group of Federal employees for which it bargains.

I think it is very unfortunate that this legislation did not put in place a model like the Federal Employees Health Benefits Plan to contain costs. But I think it has to be noted that some baby steps in the right direction have been taken with respect to cost containment. The bill begins to leverage the potential bargaining power of 30 million seniors by giving older people the opportunity to join large managed care plans and big fee-for-service plans that can use their sheer numbers to negotiate discounts for older people on their medicine. The bill also removes some of the barriers to getting cheaper generics to market faster.

It also recognizes that there is great value in comparing the effectiveness of similar drugs so seniors, providers, and the Government can spend funds on the best medicines at the lowest cost. This is very much in keeping with the way my own State has approached cost containment.

I do wish this bill went further on cost containment. There should be a way to bargain for even bigger segments of the elderly, not just the fractions of the population who end up in HMOs or various private health plans.

I am concerned that while private plans have the power to bargain under this bill, the Medicare Program is barred from giving seniors the kind of bargaining power that Senator SNOWE and I wanted them to have in our model that looked to the Federal employee program for seniors.

I am also concerned that there is not ongoing monitoring to assure that drug prices are not increased unfairly before the bill takes effect, or in the first few months after it does.

So the legislation does not contain costs the way Senator SNOWE and I would have liked. It does take some modest steps in the right direction. It borrows from the principles of our legislation, but in the end I strongly believe that more and better cost containment measures with respect to prescriptions are going to be needed in the future.

Next, I asked: Does this legislation address Medicare's broader challenges, including the large number of retirees that will join in the near future? A demographic tsunami is about to occur in our country. As the baby boomers come of age, there are going to be extraordinary pressures on our health care system. Health care advances mean that seniors will live longer, and many of those advances will come in pill form. What is exciting is that the more researchers learn about the way medicines affect individuals, the more personalized treatments, emphasizing pharmaceuticals, will become. Drugs that work one way for Bob will work differently for Mary. In the years ahead, I believe a new field known as ''personalized medicine through pharmaceuticals'' is going to help to increase the quality of patient care and cut down on wasteful spending.

As of now, however, baby boomers face the prospect of joining a Medicare Program that is already short of funds. That is why the $400 billion authorized in this legislation is a lifeline for the baby boomers who are going to retire in just a few years. Those funds provide some measure of security for future retirees, and some tangible evidence that Congress is laying the groundwork to support the growing Medicare population which will need both prescription drugs and the broader program.

There are several modest benefits in this bill, in addition, that sounds exciting to me for Medicare's future. One would focus on an approach known as disease management. This is going to be attractive in the years ahead because it will allow many of our country's future seniors to have better, more cost-effective care for chronic conditions. Medicare has lacked this benefit.

In addition to these direct benefits for seniors, the legislation helps gear up Medicare for the baby boomers with significant increases to many deserving health care providers. Over 10 years, hospitals in my State will receive almost $95 million. I am especially pleased that a number of medical providers, a number of our hospitals that now see a small number of patients and those that have a large share of patients who are too poor to pay for their care, would get help.

In addition, doctors across the country who are expecting decreases in Medicare reimbursements in 2004 and 2005 would find this reduction blocked in this legislation. In fact, the legislation increases Medicare provider payments in both of the years where otherwise there would be cutbacks. This is important because Government cost shifts have already cut reimbursement to doctors, many of whom have large numbers of low-income patients, to record lows.

I would also note that these benefits to providers will be especially useful in rural areas where we have the nationwide crisis with respect to declining access as a result of providers simply not being able to stay in business.

Finally, I ask one last question that looked beyond the issue of prescription drugs. I asked: Is there any way this legislation could provide a path to a health care system that works, not just for older people, but for all Americans?

There is a provision in this bill that offers health care hope, not just to seniors, but for all Americans. It is a provision that I helped to write with Senator HATCH, based on our Health Care that Works for All Americans Act. This legislation would ensure that, for the very first time, the American people would be involved in the process of comprehensive health care reform. There would be a blueprint for making health care more accessible and more affordable, not just to seniors, but for all Americans.

Senator HATCH and I have been able to convince those on the Medicare conference committee that the key is to make sure that the public understands what the real choices are with respect to health care, how the health care dollar is used today, and how it might be used in the future.

In 1993, then-President Clinton announced his intention to create a health care system that worked for all Americans. But by the time that 1,390-page bill was written with no input from the public, sent to the Congress, and torn apart on the airwaves by special interest groups, the people couldn't distinguish the truth from the special interest spin, and the effort died. Without public support, the opportunity for change was lost.

The bipartisan leadership of the Senate at that time has told Senator HATCH and I that, had our bill been in effect in 1993, our country would be well on its way to implementing a system that ensured coverage for all our citizens. So I think it is of additional benefit that this legislation gives us a chance to restart the debate that died in 1994. Our legislation creates a Citizens Health Care Working Group that would take steps, through on-line opportunities, townhall meetings and other forms, to involve the public; and then there is a requirement, after that public involvement, that the Congress follow up on the views that come from the citizens' participation.

There are tough calls to be made in today's health care system, including in the Medicare Program. But it is time to make them together. I think if one lesson has been learned in the last few months of discussion about prescription drugs, it is that health care is like an ecosystem. When you make changes in one area, such as prescription drugs, it can affect many other areas, such as corporate retiree benefits, provider payments, and various other parts of the health care system.

The legislation Senator HATCH and I have put together and which is included in this conference report treats health care as an entire and a system-wide concern for the American people. Nothing is taken off the table. I believe there is in that legislation a path to making sure this Congress helps not just older people but sets out ways to ensure that all Americans have access to good quality and affordable health care.

Finally, let me note that collegiality hasn't exactly been one of the watchwords of the debate over this legislation. There have been some very cold considerations entering into this discussion. I know that some believe passage of this legislation will hand the President a great victory. Others on the other side of the aisle say Democrats who oppose this bill shouldn't dare raise questions. Those aren't the concerns that ought to drive the debate on Medicare at a time when the country has to get ready for a demographic phenomenon. Polarization and division do not do our country any good.

This legislation is a very tough call for me and I think for many others.

Congress could make a mistake by believing the $400 billion available in this legislation will still be there in February of 2005. As a member of the Budget Committee, I know how hard it has been to get funding for this benefit. When Senator SNOWE and I began in 1999 to work for funding for a drug benefit, the Senate thought we lassoed the Moon when we successfully got $40 billion in the budget. How then can you argue that Congress should walk away from $400 billion?

I wish there were a better bill. I wish it didn't include medical savings accounts and premium support and had done better in the area of cost containment.

There are going to be various procedural considerations that may come out, and I intend to weigh each of them before I vote on those procedural concerns. If it finally becomes clear that the bill, as is, represents the Senate's sole opportunity to inject $400 billion in long-sought prescription drug benefits in Medicare, I will vote yes.

At the end of the day, I will not vote to let the last train that leaves the Senate go out without $400 billion that can be used to help vulnerable seniors and those who are getting crushed by prescription drug costs. I will continue to fight to make this legislation better and for better health care for all Americans.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, the opponents of this bipartisan Medicare bill have made the claim that 6 million seniors are hurt by this bill. The other side has also claimed that 25 percent of seniors will be forced to pay more for their prescription drugs under this bill.

I want to be very clear that this is not accurate at all. I'm here to tell the American public the truth.

The truth is that 14 million lower income seniors and disabled Americans are benefited greatly by this bipartisan bill. These 14 million people will get very generous prescription drug coverage through Medicare in this bill.

First, as you can see on this chart, 7.8 million seniors and disabled Americans get full coverage with no deductible, no gap in coverage, and would pay only $2 for generic drugs and only $5 for brand name drugs. And if these seniors reach the catastrophic coverage limit, then they will get their prescriptions fully covered with no copays. That's right, no copays at all.

Next, as you can see on the chart, an additional 4.4 million lower income seniors will get even more generous coverage. These Seniors will pay only $1 for generic drugs and only $3 for brand name drugs. And if these seniors reach the catastrophic coverage limit, then they too will get their prescriptions fully covered with no copays.

In addition, some of these people are enrolled in both Medicare and Medicaid and are living in a nursing home—about 1.3 million of them. This bipartisan bill creates a special benefit for these people. For them, Medicare will cover 100 percent of the prescription costs. They pay nothing.

These groups of seniors in total represent 12.2 million seniors and disabled Americans.

The bill also provides coverage to about 2 million more lower income seniors and disabled Americans. These seniors have 85 percent of their drug costs covered after meeting a $50 deductible, and if they hit the catastrophic coverage limit, they would pay only $2 for generic drugs and $5 for brand-name drugs.

This is full coverage with no coverage gap and 85–98 percent of drug costs covered for about 14 million seniors and disabled Americans. That is about 36 percent of all Medicare beneficiaries.

That is what this bill does. It provides very generous prescription drug coverage through the Medicare program for about 14 million lower income seniors and disabled Americans. And it provides this full coverage to 8 million lower income seniors who have no coverage at all today.

On top of that, of course, this bill provides all beneficiaries with access to basic prescription drug coverage with protections against catastrophic drug costs. The average beneficiary who does not quality for the low income benefits I have just described will still have about half of their drug costs covered under this bill.

Finally, no one is forced into this drug benefit. It is a purely voluntary benefit. No one is forced to enroll and any senior or disabled American that does not see the drug coverage offered as a good deal for them does not have to enroll.

So this bipartisan bill before us does not harm seniors. That is an absurd charge to make by the opponents of this bill.

This bill provides an affordable, voluntary and universal drug benefit for all seniors and disabled Americans in this country. And it provides very generous coverage to those 14 million lower income beneficiaries.

It is time to put the partisan rhetoric aside and approve this bipartisan bill that the AARP calls ''an historic breakthrough and [an] important milestone in the nation's commitment to strengthen and expand health security for its citizens.